LOS ANGELES COUNTY – DEPARTMENT OF MENTAL HEALTH / *CENTRAL BUSINESS OFFICE*

CBO DISPATCH

The "B" means BUSINESS

CBO Dispatch No.: NGA 15-006 Issue Date: March 27, 2015

Client's Request for Restricted Use and Disclosure of Protected Health Information

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule allows clients to have the right to restrict the use and disclosure of Protected Health Information (PHI) to a health plan. This means that clients may restrict the use and disclosure of their PHI to Medi-Cal, Medicare, or another insurance or health plan; however, in exchange, the client is then responsible for paying out of pocket for the full cost of services provided. Providers are responsible for obtaining payment at the time that services are provided.

The following policy and procedure provides direction for the implementation of this restriction. The forms associated with this policy are included with this Dispatch.

This policy is effective immediately. All providers must follow this policy and the procedures described therein upon a client's request to restrict disclosure of their PHI.

PURPOSE

1. To establish a policy pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule to ensure that clients have the right to restrict the use and disclosure of protected health information (PHI) to a health plan.

POLICY

2. Los Angeles County Department of Mental Health (DMH) staff and all Non-Governmental Agency (NGA) contracted staff will allow an individual to request to restrict the use and disclosure of their PHI to a health plan if: (1) the disclosure is for purpose of payment or for health care operations and is not otherwise required by law, and (2) the PHI pertains solely to health care items or services for which the individual or another person on behalf of the individual (other than the health plan), has paid in full ("Required Restrictions").

- **Medical Records:** Providers do not need to create separate medical records or segregate PHI subject to a Required Restriction. However, they will need to use some method to identify portions of the record that contain PHI subject to a Required Restriction to ensure it is not inadvertently sent to or made accessible to the health plan for payment or health care operations purposes.
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- **Bundled Services:** If a client requests a restriction with respect to one of several items or services provided in a single client encounter, the provider should counsel the client on the ability or inability to unbundle the services and the consequences of doing so (i.e., the health plan may still be able to identify the services performed based on the context). If the provider cannot unbundle the items or services, the provider should give the client the option to restrict and pay out-of-pocket for the entire bundle of items or services.

- **Dishonored Payments:** Providers do not need to abide by a restriction if a client's payment is dishonored. However, providers are expected to make reasonable attempts to resolve payment issues with the patient prior to disclosing PHI to the health plan. Providers may require payment in full at the time the restriction is requested to avoid payment issues.

- **Downstream Providers:** Providers are not required to notify downstream providers of Required Restrictions. This is the responsibility of the client. Providers should counsel clients that for the restriction to apply to other providers, the client must pay out-of-pocket and request a restriction when care is rendered by other providers.

- **Follow-Up Care:** Providers may include previously restricted PHI when billing the health plan for the follow-up treatment if the client does not request a restriction and pay out-of-pocket for the follow-up treatment and if it is necessary to have the follow-up treatment deemed medically necessary.

- **Health Management Organizations (HMO):** Contractual requirements for a provider to submit claims to an HMO do not exempt the provider from obligations regarding Required Restrictions.

- **Mandatory Billing Rules:** A provider may submit PHI to a government health plan as required by law (i.e., mandatory claim submission laws). However, there are various mechanisms that allow a provider to avoid such legal mandates (i.e., if the client refuses to authorize submission of a bill to Medicare). Providers must utilize such mechanisms in order to comply with the request for a Required Restriction.

PROCEDURE

DMH and NGA Provider Responsibilities:

- DMH and NGA clinic personnel shall permit a client to request to restrict the use and disclosure of their PHI to a health plan if: (1) the disclosure is for purposes of payment or health care operations and is not otherwise required by law, and (2) the PHI pertains solely to health care items or services for which the individual or another person on behalf of the individual (other than the health plan), has paid in full ("Required Restrictions").

- DMH and NGA clinic personnel shall require that the client complete the attached Client's Request for Restricted Use and Disclosure of Protected Health Information. Completion of this form includes the client demographics and the specific service(s) type/code and date(s) that the client doesn't want billed to their health plan.

- DMH and NGA clinic personnel shall explain the following to the client if their health plan is Medi-Cal:

    - There are no life-time limits with Medi-Cal
    - There is no Explanation of Benefits sent to the client via mail as with other health plans
    - If the client has a share of cost and Medi-Cal was billed, the share of cost would be "spent down" but the client would still only owe the annual liability obtained through financial screening
    - Billing of Medi-Cal is the Health Care Agency's method for obtaining, at no cost to the client, State and Federal dollars to help offset the cost of treatment.

- DMH and NGA clinic personnel shall require all clients that request that their PHI be restricted to initial and sign the attached Restricted Use and Disclosure of PHI Financial Obligation Agreement for Full Cost of Care. This form is to be issued on clinic letterhead.

- DMH and NGA clinic personnel shall collect the full cost-of-care at the time that the service is provided. In the event that the actual cost of the service is not known at the time the service is rendered due to the progress note not being completed when the client is ready to leave, the clinic personnel shall estimate the cost of the service using the clinician's scheduled face-to-face time. The balance of the charge will be billed to the client when the progress note has been finalized.

- DMH and NGA clinic personnel will allow a client to revoke the restriction of use and disclosure of PHI by completing the page 2 of the Client's Request for Restricted Use and Disclosure of Protected Health Information.

- DMH and NGA clinic personnel shall not "spend-down" a client's share of cost when a restriction is placed on the use and disclosure of PHI. Share of cost may be spent down for services provided after the date of termination of the agreement or after the date the client revokes the restriction.

- DMH and NGA clinic personnel will terminate the agreement and no longer restrict use and disclosure of PHI for nonpayment of the full cost-of-care after 60 days from the date of service or of the invoice date.

- DMH and NGA clinic personnel, upon termination of the agreement, will financially screen the client and apply the Uniform Method of Determining the Ability to Pay (UMDAP) sliding scale fee. The UMDAP amount will be applicable for services provided after the date that the agreement was terminated. Clients who refuse or do not provide the required documents to allow medical claims to be sent to their health plan, will be responsible for the full cost of all services provided.

NGA Provider Responsibilities:

- Upon notification of a client who has chosen to exercise their right to restrict the use and disclosure of PHI, the NGA will bill the client the full cost of care for any services provided by the clinic.

- The NGA will bill any third-party in the event that the client's invoice has become past due (60 days from the date of service or of the invoice date).

DMH Provider Responsibilities:

- DMH clinic personnel shall email the Central Business Office (CBO) at RevenueManagement@dmh.lacounty.gov to inform that a client has requested the PHI restriction. The email shall include the client name, client identification number, date of birth, and the name and provider number with the contact information of the clinic personnel.

- DMH clinic personnel shall scan the completed Client's Request for Restricted Use and Disclosure of Protected Health Information and the completed Restricted Use and Disclosure of PHI Financial Obligation Agreement for Full Cost of Care into the client's folder in the Integrated Behavioral Health Information System (IBHIS).

- DMH clinic personnel shall set-up the Financial Eligibility information within IBHIS with the following guarantors:

    1. Self-Pay (UMDAP)
        → Enter the Gross Monthly Income as $999,999.99 in Family Registration
    2. LA County

- Please note that if other third-party guarantors apply, the information/documentation is to be scanned into the client's folder in IBHIS.

- DMH clinic personnel shall email the Central Business Office (CBO) at RevenueManagement@dmh.lacounty.gov to inform that a client has revoked the PHI restriction. The email shall include the client name, client identification number, date of birth, and the name and provider number with the contact information of the clinic personnel.

- DMH clinic personnel shall scan the completed page 2 of the Client's Request for Restricted Use and Disclosure of Protected Health Information when a client has revoked this restriction into the client's folder in the IBHIS.

CBO Responsibilities

- Upon notification of a client who has chosen to exercise their right to restrict the use and disclosure of PHI, CBO will bill the client the outstanding balance of the full cost of care for any services provided by the clinic.

- CBO will notify the clinic in the event that the client's invoice has become past due (60 days from the date of service or from the invoice date).

- CBO will bill any third-party in the event that the client's invoice has become past due.

WE'RE WORKING FOR YOU...

If you have any questions or require further information, please contact CBO at (213) 480-3444 or RevenueManagement@dmh.lacounty.gov.

CLIENT'S REQUEST FOR RESTRICTED USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH (LAC-DMH)

I request that the **Los Angeles County Department of Mental Health** restrict the use and disclosure of the following protected health information (PHI) to my health plan concerning services for which **I agree to pay LAC-DMH** out of pocket. I understand I may be responsible for the full cost services provided. I understand that if this amount becomes past due (60 days from invoice date), I will be subject to revocation of this agreement and a medical claim will be sent to my health plan for payment.

Specifically, if my health plan is Medi-Cal, I am requesting that Medi-Cal not be billed even though it has been explained to me that:

- There are no life-time limits with Medi-Cal
- There is no Explanation of Benefits sent to me via mail, as with other health plans
- If I have a share of cost and Medi-Cal were billed, my share of cost would be 'spent down' but I would still only owe the UMDAP amount
- Billing of Medi-Cal is the Health Care Agency's method for obtaining, at no cost to me, State and Federal dollars to help offset the cost of my treatment.

_____ _____ _____

Name of Client | Client Date of Birth | Client ID #

_____ _____

Street Address | City, State, Zip

Mailing address for future correspondence regarding this restriction:

_____ _____

Street Address | City, State, Zip

Telephone Number _____FAX Number_____

List service(s) type/code and date(s) you do not want billed to your health plan

_____

_____

You may also enter services provided from date _____to date:_____

This restriction shall be in effect until date or date of event: _____

I have had an opportunity to review and understand the content of this Restriction of Use and Disclosure Protected Health Information. By signing this restriction, I am confirming that it accurately reflects my wishes.

_____ Date_____/_____/_____

Signature of Client / Personal Representative

If signed by other than the client, state relationship and authority to do so: _____

CLIENT'S REQUEST FOR RESTRICTED USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH (LAC-DMH)

Right to revoke this restriction of use and disclosure protected health information. I understand that I have the right to revoke this restriction at any time by directing LAC-DMH in writing. I may use the Revocation of Authorization to restricted use and disclosure my protected health information at the bottom of this form, mail or deliver the revocation to:

_____ _____

LAC DMH Contact Person Name LAC-DMH Agency Name

_____ _____

Agency Street Address City, State, Zip

Conditions: To the extent permitted by law, for nonpayment, LAC-DMH will terminates this agreement and will no longer restrict the use and disclosure of my protected health information effective _____(date) .I understand my request for a restriction does not affect my ability to obtain treatment.

REVOCATION OF AUTHORIZATION

SIGNATURE OF CLIENT/LEGAL REP: _____

If signed by other than client, state relationship and authority to do so: _____

DATE: _____/_____/_____
Month Day Year

For more information about your health privacy rights, ask the Treatment Team for a copy of LAC-DMH **Notice of Privacy Practices**. You may also obtain a copy by visiting our website at http://dmh.lacounty.govor by sending a written request to:

Patient's Rights Office
Los Angeles County Department of Mental Health
550 S. Vermont Ave., 5th Floor
Los Angeles CA 90020

Thank you for providing us with this opportunity to serve you and look forward to continuing to serve your healthcare needs.

(On clinic letterhead)

Restricted Use and Disclosure of PHI

Financial Obligation Agreement for Full Cost of Care

You have requested to exercise your right to request that the Los Angeles County Department of Mental Health restrict the use and disclosure of your protected health information (PHI) to your health plan concerning services for which **you agree to pay the full cost** for the services provided out of pocket.

Initial the following:

_____ I understand that I will be responsible for the full cost of services provided.

_____ I understand that payment will be expected at the time service is provided and if not paid I will receive an invoice by mail.

_____ I understand that if this amount becomes past due (60 days from the date of service or of the invoice date), I will be subject to revocation of this agreement and a medical claims will be sent to my health plan for payment.

_____ I understand that if this agreement is revoked and I refuse or do not provide the required documents to allow medical claims to be sent to my health plan, I will be responsible for the full cost of all services.

_____ _____
Client or Personal Representative Signature Date

_____ _____
Clinic Representative Date

_____ _____
Client Name Client ID Number